NOSORH Response for Ways and Means Committee RFI

Question 1: What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?

NOSORH believes that the underlying health care related factors affecting patient outcomes in rural communities is ***inadequate capacity*** of services and systems in those communities:

- **Inadequate health service capacity** - including capacity for both preventive and clinical services. Clinical services include medical, dental and behavioral health services.
- **Inadequate adjunct service capacity** - including social services, case management services and housing services. These services help to address the social and environmental determinants of health.
- **Inadequate regional health care systems** - including the formal structures needed to assure that a rural resident can have ***coordinated care*** from both local community service providers and out of area service providers.

  These structures will allow rural community providers to refer to specialists, not available locally, in out of area communities. The structures will also allow rural community service providers to make referrals to arrange for admission of local residents into inpatient facilities in out of area communities. Finally, these structures will assure that there is a coordinated care plan for rural residents bridging local and out-of-area providers. This would include appropriate discharge plans from inpatient facilities that assure that rural community providers are aware of needed follow-up.

Assuring adequate capacity for rural community services is a complex task. It will require a multifaceted approach. Appropriate payment levels and supplemental support will be an important part of the needed response. Suggested approaches to these problems are detailed below in answers to other RFI questions.

Question 2: What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

NOSORH believes that coordinated care management for rural communities - including coordination of both clinical services and social and family support services – has shown

itself to have a positive impact on rural population health outcomes. These services have been shown to be particularly effective for individuals with chronic disease and disability. They are similarly effective for individual with higher risks – both socioeconomic risk and health risk. The Community Care of North Carolina program has documented the success of such services

NOSORH notes that the digital divide continues to be a problem for much of rural America. The 2018 FCC Broadband Deployment report indicates that in rural areas only **68.6% of residents have access to the minimum standards for broadband, compared to 97.9% of urban residents**. These figures indicate a continuing problem. Access to high speed broadband for rural residents has dropped only a small percentage since the implementation of the National Broadband Plan of 2010. The figures suggest the limited potential of telehealth as a solution for rural residents outside of a clinical setting.

NOSORH notes that the higher speed connectivity needed by hospitals - at least 100Mbps – is more readily available in urban areas but less available in rural areas. Urban area health care providers also have better access to the highest speed connectivity – over 1 Gbps. This suggests that telehealth responses to the health needs of rural Americans can only be a partial solution.

Question 3: What should the Committee consider with respect to **patient volume adequacy in rural areas**?

NOSORH believes that health policy must recognize that certain health services are essential for rural communities. NOSORH also believes that the low-volume services in these communities will require supplemental financial and technical support to reach or maintain the minimum service capacity needed.

NOSORH believes that it is important to specify minimum standards for services to be provided in rural communities. This will provide a framework for rural health system improvement. The NOSORH Rural Integrated Service System model (RISS) is an example of such a framework. RISS sets out essential clinical services and supporting services which rural residents should expect in their communities. RISS provides separate models for three different types of rural community.

NOSORH believes that any effort to improve rural health system adequacy must address the question of ***adequate financial support for low volume essential health service providers***. These efforts should include ***enhanced reimbursement rates*** for essential rural providers – such as Critical Access Hospitals (CAHs) and Rural Health Clinics (RHCs) - as well as ***direct financial support for some providers*** – such as the Community Health Center grant program. NOSORH believes that these approaches should be expanded to include a broader range of essential rural providers, including community hospitals larger than the CAHs with more than 25 beds. Approaches should also provide enhanced funding for a wider range of clinical and non-clinical services.

NOSORH notes that reauthorization of Medicare Physician Scarcity Area payments for specialists would be a good first step.

Question 4: What lessons can we glean from service line reduction or elimination in hospitals that serve underserved communities where —

a. patients have the option to transition to alternative care sites, including community health centers and federally qualified health centers?
b. there is broader investment in primary care or public health?
c. the cause is related to a lack of flexibility in health care delivery or payment?

No response submitted.

Question 5: If states or health systems have formed **regional networks of care**, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist?

No response submitted.

Question 6: What **successful models** show a demonstrable, positive impact on addressing **workforce shortages in rural and underserved areas?** What makes these models successful?

A comprehensive approach is needed to address rural health workforce shortages. This must include expanded ***programs to train, place and retain the health workforce*** needed in rural health systems. Health workforce considerations must cover all health service providers, including advanced care practitioners. These practitioners, including advanced practice nurses and physician assistants, are becoming increasingly essential for rural communities.

Expanded training must include expanded rural-oriented programs – particularly those which produce generalist primary care health providers and providers of key specialties such as obstetrics/gynecology, general internal medicine, general surgery, cardiology, endocrinology, urology, pulmonology and psychiatry. The key specialties are those required for addressing prenatal care, delivery and chronic disease treatment for rural communities. Consideration should be given to expanding the number of Medicare supported residency slots in primary care and the key specialties.

Placement incentives for rural areas should be expanded. This could include support for completely subsidized health professional education conditioned upon commitments to serve in rural areas. The National Health Service Corps and multiple state program models have demonstrated their value as successful approaches of this type. The Conrad

J-1 Visa Waiver program should also be expanded beyond the 30 physician per state annual limit.

New and expanded retention incentives should be made available for rural providers. These should include enhanced payment, retention bonus and tax incentive bonus programs. Successful rural provider tax credit programs in Oregon and New Mexico can be replicated. It is less expensive to retain existing health care providers than to train and place new ones.

Question 7: Access to providers that address **oral, behavioral, and substance use needs** in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such **gaps in care delivery**?

No response submitted.

Question 8: The availability of **post-acute care and long-term services and supports** is limited across the nation but can be particularly challenging in rural and underserved areas facing disproportionately large burdens of chronic and disabling conditions. What **approaches** have communities taken **to address these gaps in care delivery** and the associated challenges of social isolation?

No response submitted.

Question 9: There are known, longstanding issues with the availability and integrity of data related to rural and urban community health. What **data definitions or data elements are needed** to help researchers better **identify the causes of health disparities in rural and underserved areas**, but are unavailable or lack uniformity?

The Patient Protection and Affordable Care Act (PPACA) requires expanded data collection and analysis in Section 3103 of Title XXXI. This section requires the Department of Health and Human Services, Bureau of Labor Statistics and the Census Bureau conduct data collection and analysis permitting identification of health service and health status disparities. Subsection (f) ***requires these agencies to examine disparities in underserved rural and frontier populations***. PPACA directs these agencies to conduct statistical oversamples for this population, if needed, and to aggregate the data at small geographic levels.

NOSORH has observed that the data needed to assess rural and frontier area health service and health status disparities is not routinely available. For example, the Behavioral Risk Factor Surveillance System (BRFSS) – a major source of adult health risk and morbidity data - routinely makes data available only at the state, metropolitan and micropolitan levels. It often suppresses data at the rural county level having sampled

at a level insufficient for accurate measurement. NOSORH believes that there is only limited compliance with the PPACA's health data mandate.

NOSORH notes the lack of uniformity in definitions of rural established by the Census, the National Center for Health Statistics, and the Economic Research Service of the Department of Agriculture. This presents challenges to the assessment of health disparities and health determinant disparities. NOSORH suggests that a more uniform set of rural definitions be developed for use at national, state, county and sub-county levels. These definitions should cover multiple levels of rural and frontier.

10. Are there **two or three institutional, policy, or programmatic efforts** needed to further **strengthen patient safety and care quality** in health systems that provide care to rural and underserved populations?

NOSORH observes that some rural health care providers are being bypassed by some managed care organizations (MCOs). This is occurring under Medicare, Medicaid and private insurance managed care. An instance exemplifying this issue can be seen at:

> https://healthcare.dmagazine.com/2018/12/10/rural-hospitals-say-they-are-being-strong-armed-by-blue-cross-blue-shield-of-texas/

MCOs argue that rural providers should be compensated at the same rate as urban providers. Rural providers counter that costs of operation in rural communities must be paid if local residents are to have ready access to health care. This must include the higher unit costs of low volume providers.

NOSORH believes that national health policy must address this question. Regulation is needed to assure that essential rural service providers are part of any managed care network. In many cases MCOs will reach contractual agreements with essential providers. In those instances where they do not, regulation must also address reasonable compensation levels for these providers which reflects the cost of operation.

Related to this is the question of market competition and anti-trust concerns. In many rural communities health care providers operate with a monopoly or other types of health market dominance. While some safe harbors exist for rural health care providers, additional legislation and regulation is needed addressing this question – including how rate setting should proceed in communities of natural monopoly or health market dominance.